Behavioral Health Intake Assessment

ADULT SERVICE, DEPARTMENT OF BEHAVIORAL HEALTH
(SEE DD FM 2005 FOR PRIVACY ACT STATEMENT)

Name: (Last, First, MI)		**SSN**		**Date**: day/mo/yr
Home Address	City	State	Zip Code	Home phone:
Age / DOB: day/mo/yr	Race: ☐Black ☐White ☐ Asian ☐Hispanic ☐Native American ☐Other		☐ Sponsor (20) ☐ Dependent: 30 31 01 02 03 04	
Gender: Male ☐Female	Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced			
Military: ☐Yes ☐No	Unit or Work Address	Military/ Occupational Specialty	Work phone	
Branch :☐Army ☐Navy ☐ Air Force ☐ Marine Corps ☐CG ☐Other		Status: ☐ Active Duty ☐ Retired ☐ Reserve Rank:		
Commander's/ Supervisor's name/grade	Work Phone	Referred by: ☐Self ☐Other ☐ Command ☐ Medical		

SPOUSE INFORMATION (OR SPONSOR IF OTHER THAN PATIENT)

Name: (Last, First, MI)	SSN	Home phone: ☐same as above OR:		
Home Address: ☐Same as above OR:	City	State	Zip Code	
Age / DOB: day/mo/yr	Race: ☐Black ☐White ☐ Asian ☐Hispanic ☐Native American ☐Other	☐Sponsor (20) ☐Dependent: 30 31 01 02 03 04		
Military: ☐Yes ☐No	Unit or Work Address	Military/Occupational Specialty	Work Phone	
Branch : ☐Army ☐Navy ☐Air Force ☐ Marine Corps ☐Coast Guard ☐Other	Status: ☐Active Duty ☐ Retired ☐Reserve Rank:			
Commander's/ Supervisor's name/grade	Work phone	Referred by: ☐ Self ☐Other ☐Command ☐ Medical		

PRESENTING PROBLEM

Narrative of presenting problem: What are you seeking help for?

Precipitants/Stressors: What do you think may have caused or contributed to your problem(s)?

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Symptoms: Mark any that apply:

- ☐ Sleep Problems
- ☐ Energy Changes
- ☐ Appetite Changes
- ☐ Weight loss
- ☐ Loss of pleasure
- ☐ Sadness
- ☐ Hopelessness
- ☐ Thoughts of hurting self or others
- ☐ Irritability
- ☐ Rage
- ☐ Anxiety
- ☐ Poor focus
- ☐ Poor Impulse Control
- ☐ Suicidal/Homicidal Thoughts
- ☐ Manic/hypomanic:
  - ☐ Spurts of extremely high energy
  - ☐ Binge spending
  - ☐ Racing thoughts
  - ☐ Mood swings
  - ☐ Reckless, impulsive behaviors
- ☐ Obsessions
- ☐ Compulsions
- ☐ Hallucinations

Functional Problems: ☐ No ☐ (1) Yes for: **Activities of Daily Living**: ☐ Eating ☐ Dressing ☐ Bathing ☐ Toilet
☐ (2) Yes for: **Instrumental Activities of Daily Living:**: ☐ Driving ☐ Housekeeping ☐ Cooking ☐ Cleaning ☐ Shopping ☐ Writing, ☐ Calling by phone ☐ Caring for child, ☐ Managing money

Past Psychiatric History

Problems/Symptoms:	Treatment	Medications

Medical History

Last visit to medical clinic:

Medical Problems:	Treatment or Rx	Provider
Pain Scale /10		

Allergies to Rx: ☐ NO ☐ Yes:	Seizures: ☐ No ☐ Yes Head Injury: ☐ No ☐ Yes	Surgeries:

Family History

Problems at birth and early development? ☐ No ☐ Yes

What was your childhood like?

Victim of abuse? ☐ **No** ☐ **Yes**: ☐ Verbal ☐ Physical ☐ Sexual

Relationship with parents?

Relationships with siblings?

If married, how would you describe your marriage?

Describe your home environment:

Children: Names, ages:

Any problems? ☐ No ☐ Yes. If yes, describe:

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SUBSTANCE ABUSE ASSESSMENT

Drug Use: ☐No ☐Yes Alcohol Use: ☐No ☐Yes

Drugs or alcohol	Amt & Frequency	Last Use

☐ Increased tolerance to drugs or alcohol
☐ Use of drugs or alcohol in the morning to steady nerves or to feel better
☐ Functional or relationship problems from drinking or using drugs
☐ Blackouts
☐ Smoking or use of tobacco products?
For how long? _____ How much? _____ ☐Interested in quitting?

SOCIAL ASSESSMENT

☐Do you have friends, or family you can talk to or ask for help? ☐Are they in the area?
☐ Do you have any other social supports? Elaborate.
☐ Do you use any community resources?

NUTRITIONAL ASSESSMENT

☐Meals are balanced/nutritious ☐Special diet ☐ Overweight ☐Undernourished
Problems with: ☐Deliberately starving oneself ☐Binge eating ☐ Laxative Abuse
☐Inducing vomiting.

EDUCATIONAL ASSESSMENT

Highest level of education completed? ☐Elementary school ☐ Junior high school ☐ High school ☐College ☐Other

Problems with: ☐ Grades: Learning ☐ Behavior:
☐Getting along with peers ☐Relating to authority figures

RELIGION/SPIRITUALITY

Religion/Spirituality affects my life ☐ not at all ☐slightly ☐moderately ☐greatly
Religion/Spirituality influences my treatment ☐ No ☐ Yes, in the following manner_____
_____
Religious Preference, if any:_____

LEGAL and/or FINANCIAL PROBLEMS

☐None ☐ Yes. Please explain.

SEXUAL ASSESSMENT

☐Diminished libido ☐ Painful intercourse
☐Difficulty sustaining an erection ☐ Unable to experience orgasm

INFORMATION FROM OTHER SOURCES

☐None
☐ Info from other providers ☐Info from relatives/friends
☐ Info as follows:_____
_____
_____

OTHER PERTINENT INFORMATION YOU WISH TO DISCUSS: